



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HOWARD H HOOD III MD
P O BOX 362
PALESTINE TX 75802

Carrier's Austin Representative Box

Box Number 54

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Date Received

May 8, 2012

MFDR Tracking Number

M4-12-2858-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per MAR guidelines"

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided designated doctor services 1/13/21 [sic] by determining maximum medical improvement (MMI) and impairment (IR) then billed Texas Mutual \$650.00 for this with one unit of code 99456-W5. (Code 99456-W8 was also billed but is not at issue in this dispute.) Texas Mutual paid the requestor \$350.00 for the MMI examination. The requestor used the lumbar spine DRE category to arrive at the IR. (See requestor's DWC-60 packet.) Texas Mutual paid the requestor \$150.00 for this. Rule 134.202 at (j)(4)(C) states, 'For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (i) Musculoskeletal body areas are defined as follows: (I) spine and pelvis; (II) upper extremities and hands; and (III) lower extremities (including feet). (ii) The MAR for musculoskeletal body areas shall be as follows. (I) \$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.' For these reasons no further payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 13, 2012	CPT Code 99456-W5-WP	\$150.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a

medical fee dispute.

2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated February 21, 2012

- CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.

Explanation of benefits dated March 27, 2012

- CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824.
- 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.

Issues

1. Were the services in dispute appropriately billed?
2. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
3. Is the requestor entitled to additional reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The requestor billed the amount of \$700.00 for CPT code 99456-W5-WP with 1 (one) unit in Box 24G of the CMS-1500 for a Division ordered Designated Doctor examination for Maximum Medical Improvement/Impairment Rating (MMI/IR).
2. Review of the submitted documentation supports that Maximum Medical Improvement (MMI) was assigned and per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is \$350.00. Review of the submitted documentation supports that MMI was assigned and 1 body area was rated. To determine reimbursement for an IR, the method of calculating IR and the number of body area/conditions are reviewed. Review of the narrative documentation submitted supports the rating of the lumbar spine (spine) using the Diagnosis Related Estimates (DRE) method per AMA Guides to the Evaluation of Permanent Impairment, 4th Edition in accordance with 28 Texas Administrative Code §134.204(j)(4)(C)(i)(I). Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I) the Maximum Allowable Reimbursement (MAR) for the Impairment Rating is \$150.00. The combined Maximum Allowable Reimbursement (MAR) for the disputed CPT code 99456-W5-WP is \$500.00.
3. The respondent has previously reimbursed the amount of \$500.00 for the disputed CPT code 99456-W5-WP. Therefore, the requestor is entitled to additional reimbursement of \$0.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

July 2, 2012
Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.